Arizona
HUMAN RESOURCES

Benefits Enrollment Guide

State Employees • 2006-2007

Benefit Options
Choice. Value. Health.

TABLE OF CONTENTS

INTRODUCTION

Benefit Options, the State of Arizona's comprehensive employee benefits package, was designed with you and your family in mind. You will notice more of an emphasis on wellness this year, because the Employee Wellness Program is one of your most important health benefits as a State employee. We want to help you be well today and stay well for life.

In this valuable reference guide, we have included explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This document is no longer just an enrollment guide, it is a resource to use throughout the year for services and benefits provided to you as a State of Arizona employee. In this guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

How to Use This Guide

The Benefits Guide is divided into chapters, each covering a specific benefits program or important information. These programs include:

- Employee Wellness
- Medical Plans
- Pharmacy Benefits
- Dental Plans
- Vision Plans
- Basic, Supplemental and Dependent Life Insurance
- Disability Plans
- Flexible Spending Accounts
- COBRA
- Additional Benefits

New Hires

Newly hired and returning employees must enroll for benefits coverage within 31 days of their date of hire or reinstatement. If you are nearing the end of your 31-day enrollment period and are not able to enroll using the "Your Employee Services" (Y.E.S.) website, contact your agency benefits liaison before the 31-day period has ended.

The effective date for your benefits coverage will be the first pay period following receipt of a properly executed enrollment form and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire.

The Benefit Options Guide is designed to provide an overview of the Benefit Options Program and the benefits offered through the State of Arizona. The actual benefits available to you and the descriptions of these benefits are governed, in all cases, by the relevant Plan Descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.

CONTACT INFORMATION CHART

Contact	Phone Number	Web Address	Policy Number
Medical Plans			
Fiserv Health - Harrington Benefits (Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson)	1.888.999.1459	www.myazhealth.com	3J
TDD/TTY	1.866.503.3463		
UnitedHealthcare	1.800.896.1067	www.myuhc.com	705963
TDD/TTY	1.888.697.9055		
Pharmacy			
Walgreens Health Initiatives	1.866.722.2141	www.mywhi.com	512298
Dental Plans			
Delta Dental	1.800.352.6132	www.deltadentalaz.com	7777-0000
Employers Dental Services	1.800.722.9772	www.mydentalplan.net	6300
Assurant	1.800.443.2995	https://www.assurantemployeebenefits.com	EA82
MetLife Dental	1.800.942.0854	www.metlife.com/dental	94739
Vision Plan			
Avesis, Inc.	1.800.828.9341	www.avesis.com	10790-1040
Flexible Spending Accounts			
ASI - InfoLine	1.800.366.4827	www.asiflex.com	
ASI - Member Services	1.800.659.3035	email: asi@asiflex.com	
Life and Short Term Disability Plans			
Standard Insurance Company	1.866.440.4846	www.standard.com/mybenefits/arizona/	617950
Long Term Disability			
VPA (ASRS Participants)	1.818.591.9444	www.vpainc.com	
Standard Insurance Company (PSPRS, EORP, CORP, OPT RET Participants)	1.866.440.4846	www.standard.com/mybenefits/arizona/	
Other Important Numbers			
Benefit Options Wellness	602.771.WELL	www.benefitoptions.az.gov/wellness/ email: wellness@azdoa.gov	
ADOA Benefits Office 100 N 15th Ave #103 Phoenix, AZ 85007	602.542.5008 or 1.00.304.3687	www.benefitoptions.az.gov email: azboquestions@azdoa.gov	

EMPLOYEE WELLNESS

Being healthy one moment is one thing. Staying healthy over the long run is yet another…

This is why one of the most important benefits for State employees is the employee wellness program, Benefit Options Wellness. The Wellness Program offers State employees and retirees, and in some instances their families, health education, screenings and more. The State of Arizona is concerned about you and wants you to be as healthy as you can be. That is why the Wellness Program's goal is to provide services that assist in keeping employees healthy, detecting concerns early and managing their and their family's health. In the last year, Wellness has provided over 500 worksite classes and screenings with almost 4,000 participants. Furthermore, in an average month, Weight Watcher members in 18 groups throughout the state lose over 900 pounds. Lastly, the Wellness Program provided 13,000 influenza vaccinations to employees, retirees and their families in 2005's flu season.

Wellness services are available at low or no-cost and are provided by contracted professionals who will travel across Arizona providing employees with health education or screening services.

The Wellness Program offers:

- Health education classes focusing on physical activity, nutrition, stress management, chronic diseases and more
- Weight Watchers at Work – 10-week sessions
- Preventive screenings including:
  - › Mini-health screening (cholesterol, blood pressure, body composition, blood glucose, optional osteoporosis and prostate specific antigen). New – you now have your results sent directly to your physician (you must supply name and address at event)
  - › Mobile Onsite Mammography –mammograms at worksites across Arizona. These results are sent directly to your physician.
  - › Skin cancer screening
  - › Onsite chair massage
  - › Annual flu vaccine program beginning in the fall each year

Benefit Options Wellness is a request-based program; services are scheduled at worksites where an employee has requested them. Therefore, the Wellness program relies on State employees to bring Wellness events to their worksite.

To learn how to request a service at your office, or for additional information and a complete listing of services, visit the website at www.benefitoptions.az.gov/wellness (also available through www.yes.az.gov).

Other Wellness Services include:

- Monthly Newsletter (wellNEWS) – this electronic newsletter is sent via email to Wellness Coordinators in each agency. Each coordinator sends the newsletter to employees within that agency.
- Wellness Program Website – the website provides many online resources the monthly newsletter, and monthly Wellness events scheduled throughout the state.
- More to come – look for more programs and services coming from the wellness program throughout the year by visiting www.benefitoptions.az.gov/wellness

What employees are saying about the services of the Wellness Program:

Wellness Services – "Thank you so much for your help setting up Wellness events for our agency. The Wellness Program has given us great service and our employees are enjoying the programs that come out of your office."

Mobile Mammography – "If MOM hadn't been available at work, I wouldn't have gotten a mammogram. I don't want to take time off work to get it done, so it's nice I could do it right at work and it only took 15 minutes!"

Mini-Health Screening – "I was unaware that my cholesterol and blood pressure was high. This screening was a wake up call for me to see my Doctor and starting living healthier. Thank you!"

Skin Cancer Screening – "Had it not been for the cancer screening (and my nagging yet wonderful husband) I could be in some serious trouble now and possibly facing chemotherapy. Thank you, thank you for providing this valuable service to state employees and their families. I urge anyone who even thinks they would like confirmation that the spot on their arm, leg or wherever, is just a mole or freckle to make an appointment and participate in the screening. It really is worth the time."

Weight Watchers – "I am so happy that a co-worker asked me to attend. This is great...at work and sharing stories with new friends especially our coach! In the past 6 weeks I've lost 10 pounds and feel great! Thanks again for the support of the state to link with this great program."

Weight Watchers – "I have lost 70 lbs. so far. I used to walk down the hall and not even look up at people, because I felt so uncomfortable. Now with more confidence I hold my head up and look people in the eye as I go down the hall. It's important to keep busy to avoid eating out of boredom. One thing I do to keep my hands busy at home is crochet."

Benefit Options Wellness is here to help you be well today and stay well for life.

ADOA
Benefit Options Wellness
100 N 15th Ave Suite 103
Phoenix, AZ 85007

602.771.WELL (9355)
Toll free: 800.304.3687
Email: wellness@azdoa.gov
Website: www.benefitoptions.az.gov/wellness

ELIGIBILITY

New Hires

Newly hired and returning employees must enroll for benefits coverage within 31 days of their date of hire or reinstatement. If you are nearing the end of your 31-day enrollment period and are not able to enroll using the "Your Employee Services" (Y.E.S.) website, contact your agency benefits liaison before the 31-day period has ended.

The effective date for your benefits coverage will be the first day of the pay period following submission of your completed electronic enrollment and/or receipt of your properly completed enrollment forms.

State employees regularly scheduled to work 20 hours or more each week (except those listed below) and their eligible dependents may participate in the Benefit Options program.

- Employees not eligible for benefits include:
- Employees who work less than 20 hours per week;
- Employees in temporary, emergency, or clerical pool positions;
- Patients or inmates employed in State agency institutions;
- Non-State employee officers and enlisted personnel of the National Guard of Arizona;
- Employees in positions established for rehabilitation purposes.

Eligible dependents include:

- Your legal spouse
- Natural, adopted and/or stepchildren under age 19, or under 25 if a full-time student at an accredited educational institution
- Natural, adopted and/or stepchildren who were disabled prior to age 19 as defined by Social Security Administration (SSA) guidelines
- Children placed in the employee member's home by court order pending adoption
- Minors under the age of 19 for whom the employee or legal spouse has court-ordered guardianship
- Foster children under the age of 18

Please note: If your dependent child is approaching age 19 and is disabled, immediately contact your agency benefit liaison regarding the procedures to continue coverage for this dependent child. You will need to provide verification that your dependent child has a qualifying permanent disability in accordance with Social Security Administration (SSA) guidelines that occurred prior to his or her 19th birthday. Documentation may be required periodically to maintain a dependent on your plan. Disability eligibility and continued coverage will be determined by the plan administrator.

Dependent Documentation Requirements

If you are enrolling a spouse or dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation, such as a

marriage license (for a spouse), birth certificate, or court order (for dependents), is provided to your agency human resources office. Subsequent verifications may be requested by plan administrators. If there is a delay in locating required documents, please contact your agency human resources office or the ADOA Benefits Office. Coverage will be suspended until all the necessary documents have been received.

Qualified Medical Child Support Order (QMCSO)
If a QMCSO exists, you must elect and continue coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO. If coverage is terminated, coverage will be reinstated retroactive to the date coverage was terminated. You will be responsible for any past due premium, collected through payroll deductions.

If You and Your Spouse are State Employees
If both you and your spouse are eligible State of Arizona employees, be sure to take into account the coverage that you each can elect.

Each of you may elect single medical, dental and/or vision plan coverage. OR, One of you may elect family medical, dental, and/or vision plan coverage while the other elects no coverage or single coverage, with different insurance plans.

Under no circumstances may an employee elect dual coverage. If it is determined there is dual coverage, you will be responsible for coordination of benefits for any claims paid under your dependent status. Health insurance premiums will not be reimbursed to either employee as a result of dual coverage.

OTHER IMPORTANT INFORMATION

Pretax Benefits
When your insurance premiums and contributions to your Flexible Spending Account(s) are made on a pretax basis, your taxable income is reduced. This means you will be paying less state, federal and Social Security (FICA) taxes and as a result you will have more take home pay.

Pretax benefits include:

- Medical Premiums
- Dental Premiums
- Vision Premiums
- Supplemental Life Insurance (first $35,000)
- Flexible Spending Accounts (medical and dependent care)

Keep in mind that any reduction in your taxable income could lead to a reduction in your future Social Security benefits. Please consult a tax advisor if you have questions about this matter.

Changing Your Benefits

You may only change your benefit elections during the year whenever you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next annual open enrollment period to make benefit changes.

Qualifying Life Events include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse;
- Changes in dependent status: birth adoption, placement for adoption, death, or dependent eligibility due to age, marriage, student status;
- Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependent;
- Changes in residence that result in different available plan options for you, your spouse, and/or dependent.

*Refer to the plan description booklet.

Timeframe to Submit a Change Request

Requested benefit changes must be submitted in writing to your agency benefit liaison within 31 calendar days of the event.

Effective Date of the Change

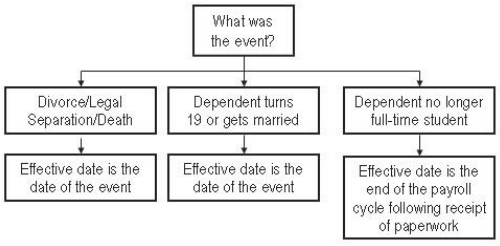
The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event. The effective date for benefit changes based on all other QLE's is the first day of the next pay period, following the date the employee submits the requested change, in writing, to his or her agency benefit liaison. Please consult with your agency benefit liaison to determine whether or not the life event you are experiencing qualifies under the regulations. Refer to the plan description booklet.

Premium Changes Due to QLEs

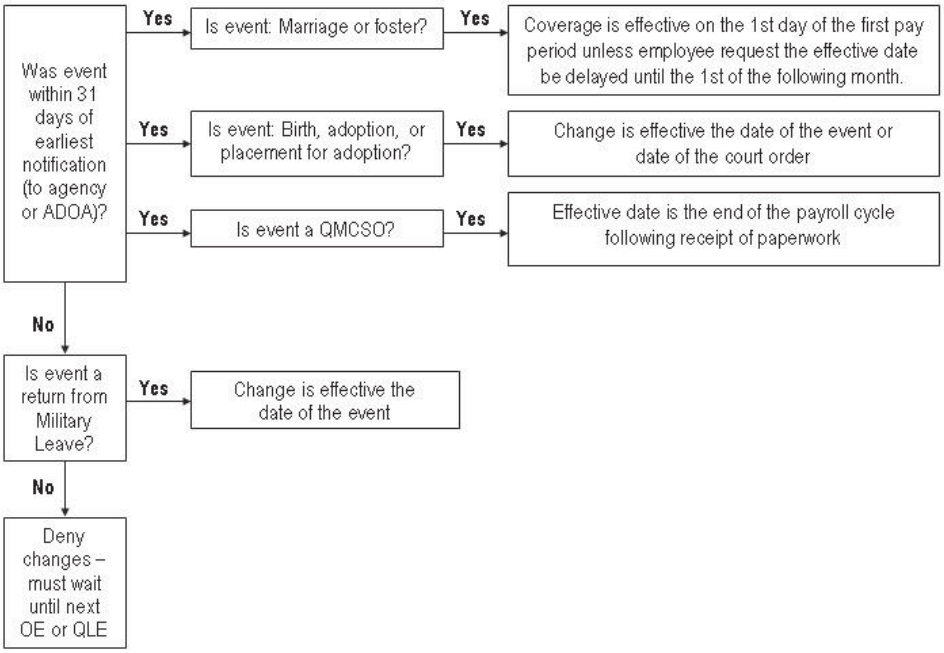
Any change in premiums due to a QLE will be in effect the pay period following the receipt of all QLE documentation. No previously paid premiums will be refunded according to IRS rules.

Refer to the following flow charts to determine the effective dates of qualified life events.

Losing Eligibility



Gaining Eligibility



PREMIUM COLLECTION - LEAVE WITHOUT PAY

Premium is collected through payroll deductions for those employees actively-at-work, or by personal payment for an employee on a leave without pay status.

Military Leave of Absence

Employees who must leave for military service are provided continued benefits through the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA provides extended health care coverage for up to eighteen (18) months. The employee may continue health coverage for a maximum of six (6) months by paying the employee portion of premiums. After the 6-month period, the employee must pay both the employee and State portion of premiums until the employee returns to work or for a maximum of eighteen (18) months.

Family and Medical Leave Act (FMLA)

Employees on approved FMLA may continue health care coverage by paying the employee portion of monthly premiums.

Industrial Injury or Illness

Employees who are on a leave without pay status due to an industrial injury or illness may continue health coverage for a maximum of six (6) months from the date of injury by paying

the employee portion of premiums. After the 6-month period, the employee must pay both the State and employee premiums until the employee returns to work or is determined to be eligible for Medicare or long-term disability, whichever comes first.

Non-Occupational Leave
Employees on leave without pay for a health related reason that is not work related, may continue health care coverage for a maximum of thirty (30) months by paying both the employee and State portions of monthly premiums until the employee returns to work or is determined to be eligible for Medicare or long-term disability, whichever occurs first.

You may elect to change your coverage level from family to single insurance during a leave without pay status; however, you must request this change at the time you enter a leave without pay status. If you are placed on a leave without pay status, please check with your benefit liaison to confirm whether you have enough leave to cover your premiums or if you will need to make personal payments. Failure to pay premiums may result in cancellation of your benefits. The insurance coverage of an individual on leave without pay who fails to pay premiums when due shall terminate at 11:59 p.m. on the first day of the period covered by the last premium or contribution paid.

MEDICAL PLAN FEATURES

What is a Plan Administrator?
A Plan Administrator is the contracted organization that processes the medical claims, provides customer service and runs the day-to-day operations of the health plan:

- If you are enrolled with the Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson networks, your plan administrator is Fiserv Health - Harrington Benefit Services.
- If you are enrolled with UnitedHealthcare, your plan administrator is UnitedHealthcare.
- The ADOA Benefits Office is the Plan Sponsor - not the Plan Administrator.

I've heard the terms, "integrated" and "non-integrated". What do they mean?
Integrated and non-integrated describe the way services are provided in each health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson, you are in the non-integrated plan. This means multiple organizations supply the health plan services:
  - › Arizona Foundation, Beech Street, RAN+AMN and Schaller Anderson provide the of hospitals and medical providers.
  - › Fiserv Health - Harrington Benefit Services provides the claims payment processes, day-to-day operations, customer service.
  - › Schaller Anderson provides the prior authorization, disease management, and medical review services.
- If you are enrolled with UnitedHealthcare the integrated plan, UnitedHealthcare

provides the following: hospital and provider networks; payment processes and day-to-day operations; and prior authorization and disease management services.

- Walgreens Health Initiatives (WHI) is a Pharmacy Benefit Manager and provides pharmacy services for both the integrated and non-integrated health plans.

What is a Pharmacy Benefit Manager?
A Pharmacy Benefit Manager provides the national network of pharmacies; mail-order service; and specialty pharmacy services. A Pharmacy Benefit Manager manages pharmacy benefits in the following ways: by providing bulk discounts on medications through the use of a formulary; by reviewing the way medications are used by members; and by implementing targeted programs to reduce overall pharmacy costs. These programs promote the use of cost-effective medications, maximize generic efficiency, and encourage proper utilization. A Pharmacy Benefit Manager also works with physicians to review medications prescribed and looks for possible lower cost alternatives.

What is an "EPO" plan and how is this different from a "PPO" plan?
An EPO is an HMO-like plan called an Exclusive Provider Organization. The EPO plan follows the same guidelines as an HMO plan. You must obtain services from a contracted network provider. A PPO plan is a Preferred Provider Organization and allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a deductible and will pay a percentage of all covered services.

The State offers "open access" in all of the EPO plans. What does this mean?
Open access refers to how you "access" physicians. Instead of getting a referral from your Primary Care Physician (PCP) to see a specialist, you may schedule an appointment directly with a specialist of your choosing. The specialist MUST be contracted within your network. However, if you wish to obtain specialist referrals through your PCP, you may do so.

If my PCP refers me to a specialist or medical provider that is NOT within my EPO network, am I responsible for the medical charges?
Yes. In the EPO plan, all medical services received must be contracted network medical providers.

If your PCP has scheduled an appointment for x-rays, laboratory tests, or specialists, you must make sure they are within your medical network.

If you are enrolled in the PPO plan, you may obtain out-of-network services and pay 30 percent of the covered charges, after you have met your deductible.

How do I find out what is covered in the health plan?
Covered benefits are described in a booklet called a Plan Description. A plan description outlines your health insurance coverage and provides information on how claims will be paid, services that require pre-certification, services that are covered and items that are excluded by the health plan. You will receive a copy of the plan description after the beginning of a new plan year. You may also view these descriptions online at www.benefitoptions.az.gov.

I have been contacted by someone and asked if I want to participate in a disease management program. What is disease management?
Disease Management is a voluntary service provided through an organization contracted with the State of Arizona, which assists members with treatment needs for chronic conditions. If you are being treated for any of the conditions listed below, you will be contacted by the Disease Management staff with further information on the program. This is a free service to provide you information, assistance, and resources to manage the following conditions:

- Asthma
- Congestive Heart Failure
- Diabetes
- Perinatal Care (before or after the birth of a baby)

What is Perinatal care? What services are available to me if I am pregnant or planning to become pregnant?
If you become pregnant, you can receive care and education through the Benefits Options Perinatal Program. This program helps future moms and their babies get a healthy start even before pregnancy begins. Resources available include:

- Preconception counseling
- Educational materials on common topics
- Screening and health assessment to help identify high risk pregnancies
- Special management of medical care by health professionals for expecting mothers with high risk pregnancies

** If you are a member of the Arizona Foundation, Beech Street, RAN+AMN network, or Schaller Anderson, you may call 1.888.999.1459 and ask for Perinatal services through the Schaller Anderson program. If you are a member of UnitedHealthcare, you may call 1.800.896.1067 and ask for information on the UnitedHealthcare pregnancy services.

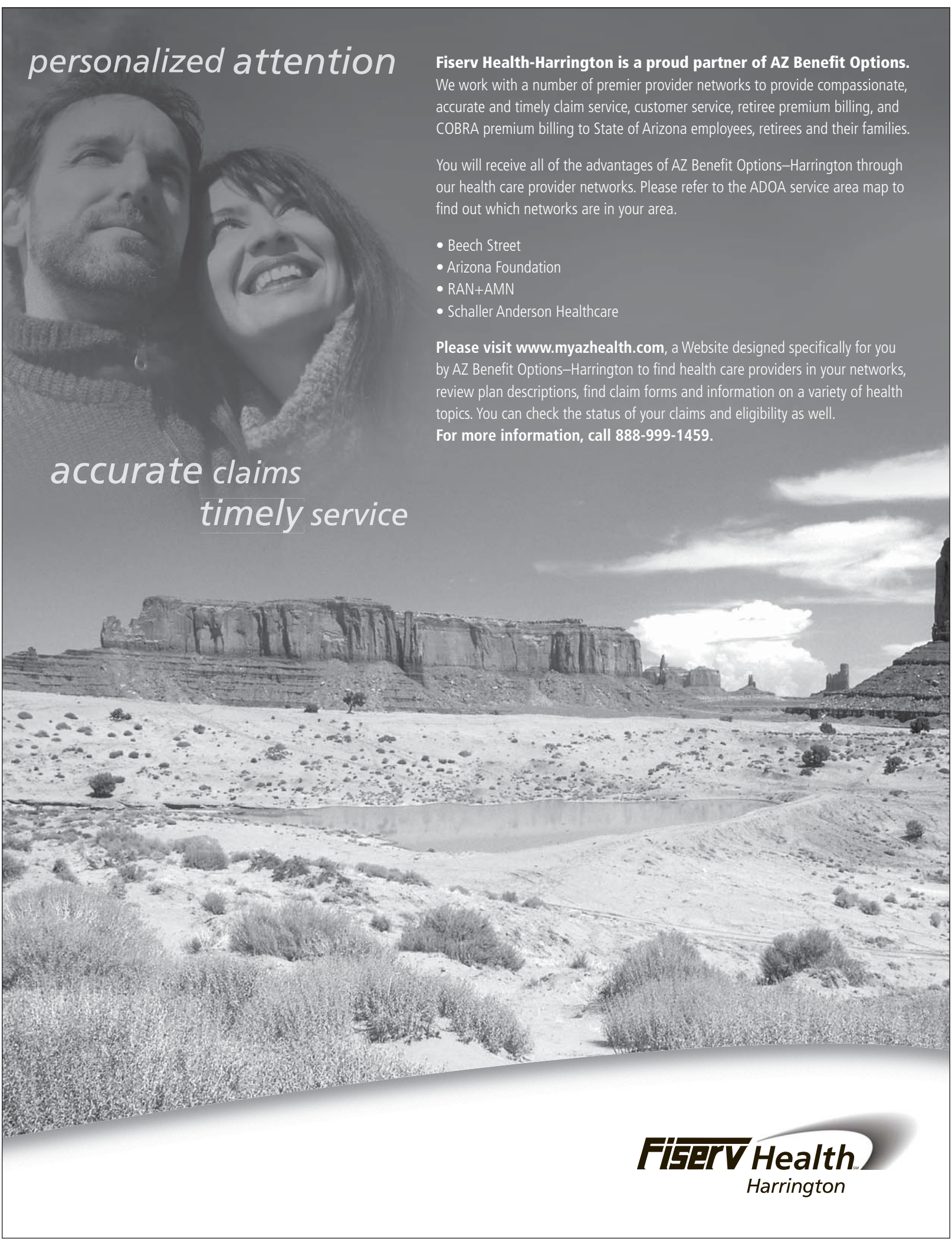
What is a network service area?
A network service area is the region in which your network is offered:

- The Arizona Foundation PPO plan is offered statewide.
- The Beech Street PPO plan is offered for members living outside of Arizona and will be used as a national travel network if you are enrolled with Arizona Foundation, RAN+AMN, or Schaller Anderson.
- The RAN+AMN EPO plan is offered statewide.
- The Schaller Anderson EPO plan is offered statewide.
- The UnitedHealthcare EPO and PPO plans are offered in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties.

If you are enrolled in an EPO plan, you are covered nationwide for emergencies and urgent care. However, you must obtain routine or scheduled services within your network service area. Members enrolled in the PPO plan are able to obtain out-of-network services nationwide.

What is Coordination of Benefits?
When an employee has more than one health plan or is considered a covered dependent under another plan, benefits are coordinated so that no more than 100 percent of the claim is paid to a medical provider. One plan will be considered primary and the other will be considered secondary. For additional information on how coordination of benefits will be applied, please refer to the appropriate plan description.

What is Transition of Care?
If you are a new employee and/or changing from Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson to UnitedHealthcare (or from UnitedHealthcare), you may continue an active course of treatment with your health care provider and receive in-network benefits during the pre-approved transition period. For additional information, please refer to the appropriate plan description.



Fiserv Health-Harrington is a proud partner of AZ Benefit Options. We work with a number of premier provider networks to provide compassionate, accurate and timely claim service, customer service, retiree premium billing, and COBRA premium billing to State of Arizona employees, retirees and their families.

You will receive all of the advantages of AZ Benefit Options–Harrington through our health care provider networks. Please refer to the ADOA service area map to find out which networks are in your area.

- Beech Street
- Arizona Foundation
- RAN+AMN
- Schaller Anderson Healthcare

Please visit www.myazhealth.com, a Website designed specifically for you by AZ Benefit Options–Harrington to find health care providers in your networks, review plan descriptions, find claim forms and information on a variety of health topics. You can check the status of your claims and eligibility as well.
For more information, call 888-999-1459.

Fiserv Health℠
Harrington

ONLINE FEATURES OF MEDICAL PLAN INFORMATION

Members can now review their personal profile, view the status of medical claims, obtain general medical/pharmacy information, and learn how to manage their own healthcare through the available health plan websites.

Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson
Members enrolled with any of the providers above, may view the following information on www.myazhealth.com (you will need to register with a user name and password):

• Personal Profile	Check your eligibility status and personal profile.
• Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
• Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
• Secure Mail	With the "Secure Mail" feature, you may ask questions anytime day or night. You will receive replies about your confidential health benefit information within 3 business days without the worry of transmitting our personal information over the internet.
• Health Information	Compare hospitals based on quality of care, procedures and patient safety measures. You may also view a medical encyclopedia, information on general health topics, and an outline of questions you should ask your doctor.
• Medline Plus	Medline provides extensive health information on over 650 diseases and conditions; provides a medical dictionary and encyclopedia; information on clinical health trials; and the latest medical research in medicine.
• Provider Search	You may click on your network to research contracted network physicians, hospitals, and medical providers.
• Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
• Claim Forms	You may download claim forms and information to submit claims for medical services and reimbursement for out-of-pocket expenses.

UnitedHealthcare

Members enrolled in UnitedHealthcare can view the following information on www.myuhc.com (you will need to register with a user name and password):

• Personal Profile	Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.
• Provider Search	Find the physicians and hospitals that are convenient and right for you.
• Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
• Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
• Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
• Hospital Comparison	Compare hospitals based on quality of care, procedures, and patient safety measures with the Hospital Comparison tool.
• Treatment Cost	Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.
• Health Information	Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and BestTreatments organizations.
• Nurseline	Chat online with Registered Nurses 7 days a week for trusted information and peace of mind when you have a question or during times when you cannot get to your doctor.
• Expert Information	Participate in monthly online events with leading experts in health care.

MEDICAL PLANS COMPARISON CHART

	EPOs	PPOs	
These plans are available to employees statewide	RAN+AMN EPO Schaller Anderson EPO	Arizona Foundation PPO Beech Street (Out-of-State only)	
In addition to the plans above, the following plans are offered to employees in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties	UnitedHealthcare EPO	UnitedHealthcare PPO	
DEDUCTIBLE/MAXIMUMS	In-Network (Copayments)	In-Network (Copayments)	Out-of-Network (Out-of-Pocket)
PCP REQUIRED FOR EACH MEMBER?	NO	NO	NO
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	NO	NO	NO
PLAN YEAR DEDUCTIBLES			
INDIVIDUAL	N/A	N/A	$300
FAMILY	N/A	N/A	$600
OUT-OF-POCKET MAXIMUMS			
INDIVIDUAL	N/A	$1,000	$3,000
FAMILY	N/A	$2,000	$6,000
LIFETIME MAXIMUMS	N/A	N/A	$2,000,000
PHYSICIAN SERVICES Office Visits/consultations, Specialist visits/consultations	$10 copay Max of 1 copay/day/provider	$10 copay Max of 1 copay/day/provider	30%
PREVENTATIVE CARE Well Baby, Child and Adult Physical Exams, Annual Well-Women Exams (GYN visit & PAP smear test) Annual Well-Man Exams (Office Visit & PSA blood test), Adult Immunizations (e.g., pneumonia, flu)	$10 copay/visit	$10 copay/visit	30%
MAMMOGRAPHY SCREENING (Coverage based on patient age or threat)	N/A	N/A	30%
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	N/A	N/A	30%
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	N/A	N/A	30%
Intensive Care	N/A	N/A	30%
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologist	N/A	N/A	30%
EMERGENCY CARE Urgent Center Care	$20 copay	$20 copay	30%
Emergency room	$75 copay waived if admitted	$75 copay waived if admitted	$75 copay waived if admitted
Ambulance (for medical emergency or required interfacility transport	N/A	N/A	Emergency paid at in-network benefit rate
PRESCRIPTION DRUGS Copays apply for in-network pharmacies only			
Retail: up to 30-day supply per copay Online/Mail-Order: up to 90-day supply for two copays			
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$20 copay	$20 copay	$20 copay
Non-Preferred Brand	$40 copay	$40 copay	$40 copay

NETWORK PLAN COVERAGE FOR ROUTINE AND URGENT/EMERGENCY CARE

	EPOs		PPOs	
	UnitedHealthcare	RAN+AMN Schaller Anderson	Arizona Foundation UnitedHealthcare	Beech Street
ROUTINE MEDICAL CARE				
Routine medical care means a regular course of treatment that is anticipated, expected, and planned for. Routine medical care is usually conducted in the medical provider's office.				
Central and Southern Arizona	Covered	Covered	Covered	Covered
Rural Arizona	Covered	Covered	Covered	Covered
Traveling in United States	Covered with UnitedHealthcare Provider	Covered with Beech Street Provider	Covered	Covered
Living Outside of Arizona	Covered with UnitedHealthcare Provider	Covered with Beech Street Provider	Covered	Covered
International Travel	Not Covered	Not Covered	Covered	Covered
URGENT AND EMERGENCY CARE				
Emergency care means the medical, psychiatric, surgical, hospital, and related health care services required to stabilize an injury or serious illness that could result in serious medical complications, loss of life, or permanent physical impairment				
Central and Southern Arizona	Covered	Covered	Covered	Covered
Rural Arizona	Covered	Covered	Covered	Covered
Traveling in United States	Covered	Covered	Covered	Covered
Living Outside of Arizona	Covered	Covered	Covered	Covered
International Travel	Covered	Covered	Covered	Covered

Covered benefits subject to plan provisions.

Choose the Health Plan chosen by more State of Arizona Employees

UNITEDHEALTHCARE®

UnitedHealthcare takes an active role in providing the tools and information to keep our members healthy, active and involved in their health, 24 hours a day, 7 days a week.

Join over 30,000 State of Arizona employees and 1.2 million members statewide and receive the following benefits:

- 24-hour access to the health information and support you need from a staff of caring, registered nurses. Simply call NurseLine℠ toll-free for information and education on any health concern, at no cost to you.
- Access to personal information anytime, anywhere on **myuhc.com**.® Check claim status, request a replacement ID card, find a physician or hospital and access health information and educational resources.
- Access to UnitedHealthcare's network of 7,645 physicians and 69 hospitals in Arizona, and a nationwide network of over 500,000 physicians and 4,600 hospitals.
- Care from any physician or hospital in our extensive network, without having to get a referral.

Choose UnitedHealthcare's EPO plan today!

UnitedHealthcare®
It just makes sense.®

If you have questions about our health care benefits, call us at **1-800-896-1067.**

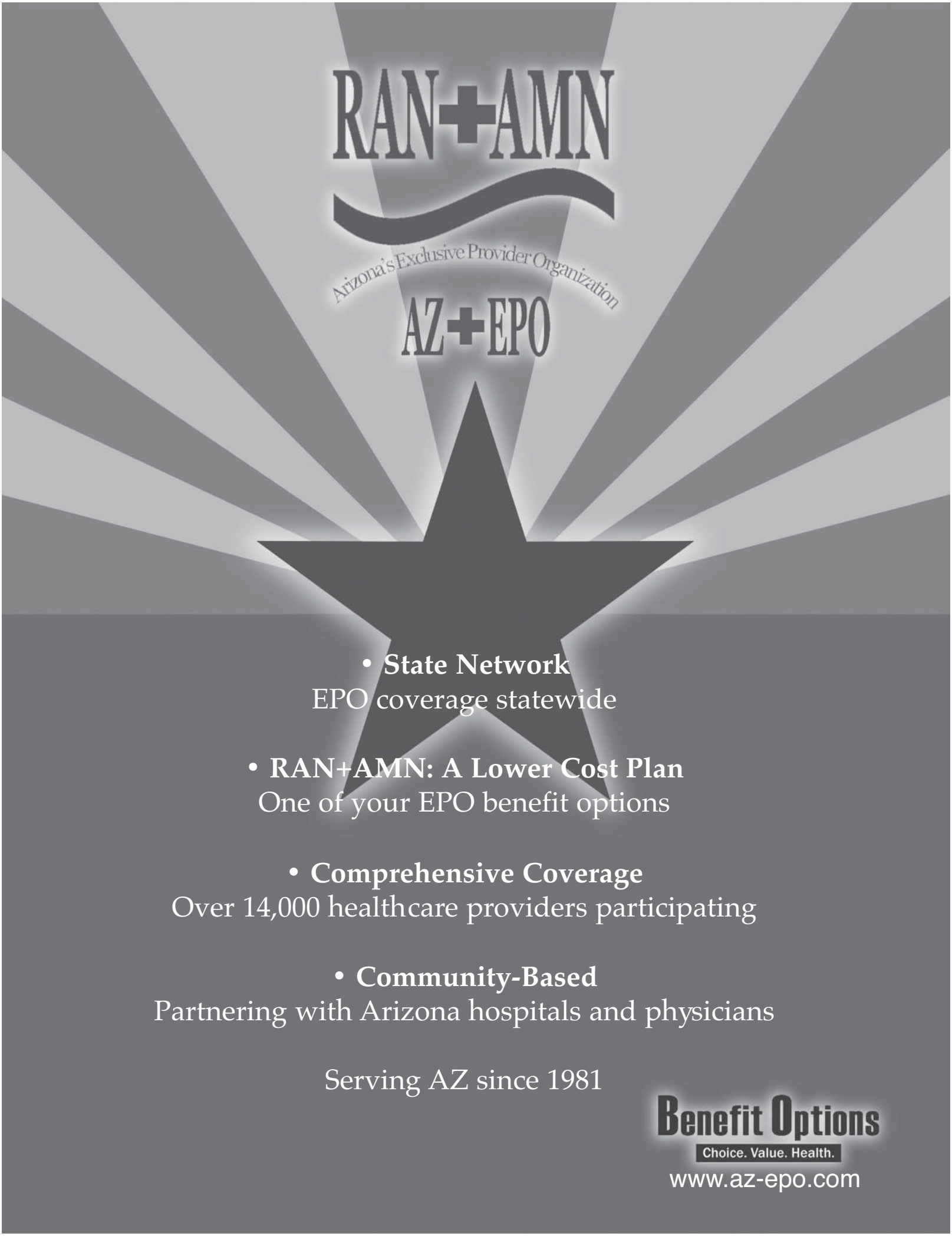
SCHALLER ANDERSON
HEALTHCARE

State of Arizona employees, now's the time to join the 60,000 employees and family members who already put their trust in Schaller Anderson. You'll have access to more than 9,000 Arizona health care providers, including Mayo Clinic. You'll also participate in one of the least expensive options available. During open enrollment, choose a company that has been earning Arizona's trust since 1986. Choose Schaller Anderson.

www.schallerandersonhealth.com

Celebrating Excellence 1986 SCHALLER ANDERSON 2006 In Health Care

Benefit Options
Choice. Value. Health.


RAN+AMN
Arizona's Exclusive Provider Organization
AZ+EPO
• State Network
EPO coverage statewide
• RAN+AMN: A Lower Cost Plan
One of your EPO benefit options
• Comprehensive Coverage
Over 14,000 healthcare providers participating
• Community-Based
Partnering with Arizona hospitals and physicians
Serving AZ since 1981
Benefit Options
Choice. Value. Health.
www.az-epo.com

HOW TO USE YOUR PHARMACY PLAN

If you elect any Benefit Options medical plan, Walgreens Health Initiatives (WHI) will be the network you use for pharmacy benefits. Coverage is part of your medical plan; enrollment is automatic when you enroll in a medical plan and there is no separate cost.

The WHI network consists of more than 54,000 participating chain and independent pharmacies nationwide, with 900 member pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work address, out-of-town vacation address or your dependent student's out-of-state address, refer to www.mywhi.com.

Multilingual customer service representatives are available 24 hours a day, 7 days a week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary also called the Preferred Medication List (PML); the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for a generic drug, $20 for a preferred (formulary) drug and $40 for a non-preferred (non-formulary) drug. You can find information on WHI's formulary and look up the cost for specific drugs at www.mywhi.com.

The Walgreens Health Initiatives Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the plan are deleted from the PML once a year, and a letter is sent to any member affected by the change. To see what medications are on the PML, log on to mywhi.com or contact the WHI Customer Care Center to have a copy sent to you. Sharing this information with your doctor helps ensure that you are getting the medications you need, and saving money for both you and your plan.

Generic drugs help you save money without compromising quality. The United States Food and Drug Administration (FDA) requires generics to be as safe and effective as their brand-name counterparts. Nearly 50% of all prescriptions in the U.S. are now filled with generic medications. Your doctor may choose to prescribe a generic for you, or, if he or she recommends a brand name, you can ask if a generic is available. Pharmacists will usually substitute a generic for a brand name, unless otherwise directed by your doctor or prohibited by law. You will pay the lowest copay for generic drugs. Generic prices on average are 20 to 50 percent lower than their brand-name counterparts, so your choice of generics can help keep the Plan's costs down and benefits high.

A convenient and less expensive mail-order service is available for employees who require maintenance medications for on-going health conditions or who are going to be in an area

with no participating retail pharmacy for an extended period of time. Here are some of the guidelines and benefits of using the mail-order services:

- You must submit a written 90-day prescription from your physician for any new mail order drug.
- You may request up to a 90-day supply of medication for two copays.
- You may pay by check or charge your copay to a Visa, MasterCard, American Express or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at www.mywhi.com or via phone at 1.866.722.2125.
- (One-on-one consultations with a licensed pharmacist are also available at this number.)

Before attempting to have a new prescription filled, it is recommended that you check WHI's online formulary to see if the medication might be categorized under one of the following Health Management Programs:

Clinical Prior Authorization
Prescriptions for certain medications or circumstances require approval from your physician before they can be filled, even though you have a valid, current prescription. Prescriptions may be limited to an amount, quantity, frequency, or may have age restrictions. The Clinical Prior Authorization can be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Specialty Pharmacy Program
Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Health Initiatives (WHI) Specialty Pharmacy. This program assists you with monitoring your medication needs for conditions such as those listed below and providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods and special storage, handling and delivery.

Medications for these conditions through the Specialty Pharmacy Program include, but are not limited to:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service. Call WHI at 1.888.782.8443 for further information on this program.

A Specialty Care Representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff are available 24 hours a day, 7 days a week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

ONLINE FEATURES OF PHARMACY PLAN INFORMATION

Walgreens Health Initiatives (WHI)

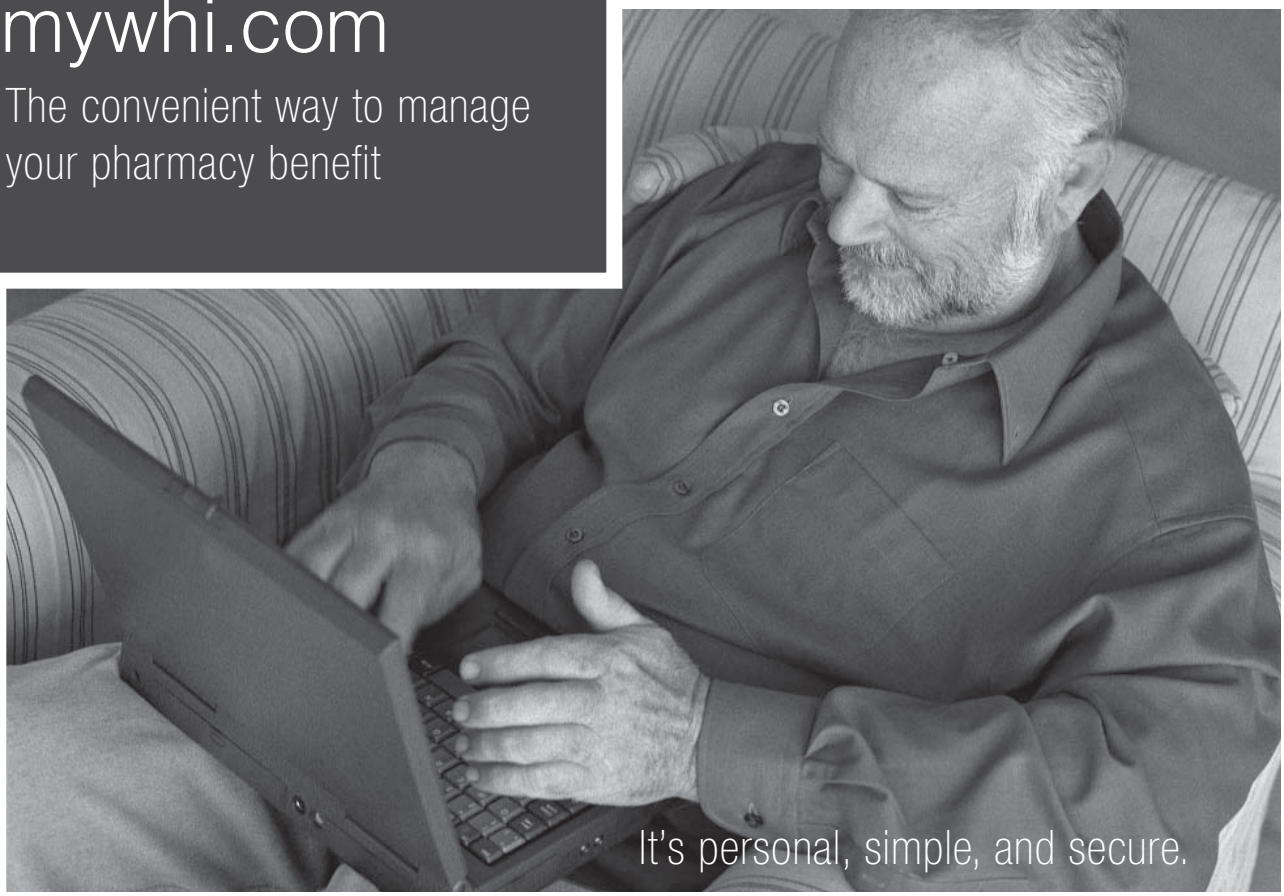
All members enrolled in Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson and UnitedHealthcare can view pharmacy information by registering at www.mywhi.com:

• Co-pay and Drug Information	You may research your medication to learn what co-pay is required at retail or through mail-order service.
• Eligibility Information	Check your eligibility status for you and your family members.
• Search the Formulary	You may research medications to determine whether they are generic, preferred or non-preferred drugs. This classification will determine what co-pay is required.
• Download the Formulary	You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
• Locate a Nearby Pharmacy	You may view pharmacies in your area by zip code or city.
• Prescription History	You may view your entire prescription history, including all of the medications received by each member.
• Mail Service Forms	You may register for mail-order service by downloading the registration form and following the step-by-step instructions.
• Refill Information	You may review refill information, including when your next refill can be ordered and available options to request your next refill.
• Drug Information	You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
• Product News	The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

Looking to save time and money on your prescriptions?

mywhi.com

The convenient way to manage your pharmacy benefit



Register today and take advantage of our many timesaving features:

- Look up your drug **coverage** and **copayments**.
- Find generic and **lower-cost** alternatives.
- See up to 18 months of your **prescription history**.
- **Locate** a network pharmacy.
- Learn more about your **medications**.
- Register for mail service to:
  - **Order refills** online
  - Check **prescription status**

You may register on or after the date your prescription coverage begins. Access to certain features may depend upon your benefit design.

Walgreens Health Initiatives

PBM4574-0706

HOW TO USE YOUR DENTAL PLAN

Following is a brief description of the dental plans available through Benefit Options. For a complete listing of covered services for each plan, please refer to the plan description located on the website, www.benefitoptions.az.gov. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your copayment.

Prepaid Plans -Employers Dental Services (EDS) and Assurant

- You see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums ($200.00 maximum reimbursement for non-contracted emergency services under EDS and Assurant).
- No claim forms (except for emergency services under EDS).

Employers Dental Services (EDS)
Employers Dental Services is the largest prepaid dental plan with the largest general dentist network in the State of Arizona. EDS is headquartered in Tucson, Arizona with offices in both Tucson and Phoenix.

Assurant
Each family member may select his or her own dentist from a group of participating dentists. Each family member may select and change his or her dentist by calling the Assurant Customer Service number located in the front of this guide. Members may self-refer for specialty care.

Indemnity/PPO Plans - Delta Dental and MetLife Dental

- You may see ANY dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- $1,500 per person per lifetime for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental
Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or copayments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

MetLife Dental
MetLife participating dental providers (PDP) accept negotiated fees as payment in full

after your deductibles and copayments are met. These fees are typically 15–30 percent below average rates. Noncovered services provided by a PDP dentist are also charged at a lower rate. Covered expenses from a nonparticipating dentist are paid according to established reasonable and customary charges.

DENTAL PLANS

	In Arizona	Outside Arizona, In U.S.	International
PREPAID PLANS			
Assurant			
Routine Care	X		
Emergency Services	X	X	X
Employers Dental Service			
Routine Care	X		
Emergency Services	X	X	X
PPO PLANS			
Delta Dental			
Participating Dentist Services	X	X	
Non-Participating Dentist Services	X	X	X
MetLife			
Participating Dentist Services	X	X	
Non-Participating Dentist Services	X	X	X

DENTAL PLANS COMPARISON CHART

	Employers Dental Services/EDS*	Assurant*	Delta Dental	MetLife Dental
PLAN TYPE	Prepaid	Prepaid	Indemnity/PPO	Indemnity/PPO
DEDUCTIBLES	None	None	$50/$150	$50/$150
PREVENTIVE CARE	100% paid, after applicable copay	100% paid, after applicable copay		
Office Visit	$5/visit	$5/visit**	100% paid, deductible waived	100% paid, deductible waived
Oral Exam	No copay	No copay	100% paid, deductible waived	100% paid, deductible waived
Prophylaxis/Cleaning	$5 copay	$3 copay	100% paid, deductible waived	100% paid, deductible waived
Fluoride Treatment	No copay for children	No copay	100% paid, deductible waived	100% paid, deductible waived
X-Rays	No copay	No copay	100% paid, deductible waived	100% paid, deductible waived
BASIC RESTORATIVE	Fixed copay***	Fixed copays		
Office Visit	$5/visit	$5/visit	80% paid	80% paid
Sealant (to age 19)	$12/tooth	$5/tooth	80% paid	80% paid
Filings	$12-$25 (amalgam)	$10-$20 (amalgam)	80% paid	80% paid
Extractions	$15 (single)	$15 (single)	80% paid	80% paid
Periodontal	Copay/procedure	$50/quadrant**	80% paid	80% paid
Oral Surgery	Copay/procedure	Copay/procedure**	80% paid	80% paid
MAJOR RESTORATIVE	Fixed copay***	Fixed copays		
Office Visit	$5/visit	$5	50% paid	50% paid
Crowns	$225-$275 (plus lab fees)	$235	50% paid	50% paid
Dentures	$300 (plus lab fees)	Copay/procedure	50% paid	50% paid
Fixed Bridgework	Copay/procedure	Copay/procedure	50% paid	50% paid
Crown/Bridge Repair	$5 (plus lab fees)	$20-$45 (plus lab fees)	50% paid	50% paid
Inlays	$112-$125	$130-$240 (plus lab fees)	(Allowance given)	(Covered Expense)
ORTHODONTIA	By Treatment Plan	By Treatment Plan		
Child	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50% paid	50% paid
Adult	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50% paid	50% paid
TMJ SERVICES	Fixed copays	Fixed copays		
Exam, services, etc.	Up to 25% of normal fees	$85-$115	No coverage	No coverage
MAXIMUM BENEFITS	No dollar limit	No dollar limit		
Annual combined preventive, basic, and major services	Benefits paid for participating dentists and/or orthodontists only	Benefits paid for participating dentists and/or orthodontists only	$2,000/person	$2,000/person
Orthodontia Lifetime			$1,500/person	$1,500/person

**Requires you to select a Participating Dental Provider (PDP) when enrolling. Out-of-State members are eligible for emergency care only with EDS and Assurant*

*** A Specialty Benefit Amendment is included in the Assurant plan that allows patients to receive certain services from Assurant contracted specialist for a specific copayment rather than the discounted fee.*

**** Copays listed are for services provided by your EDS General Dentist (PDP). EDS specialist offer up to 25% off their normal office fees for covered procedures.*

WE GIVE ARIZONA'S STATE EMPLOYEES A REASON TO SMILE FROM EAR TO EAR.

Whether it's Delta Dental's roster of dentists – literally thousands – located all over the state, or our friendly, local service with less paperwork, more people choose Delta Dental than any other dental plan. It's no wonder that Arizona's No. 1* dental plan is also the dental plan chosen by more State Employees. Find out what so many of your co-workers and their families are smiling about! **Visit www.deltadentalaz.com.**

DELTA DENTAL®

*Rated No. 1 according to *The Business Journal Book of Lists*, 2006 and *Ranking Arizona*, 2006.

Are your Dental Benefits Appropriate?

MetLife®

Now you can plan for unexpected dental care costs with the MetLife® Preferred Dentist Program (PDP)!

Here's what you get with the PDP:

- **Freedom of choice:** Freedom to visit any dentist whether or not he or she participates in the PDP. Plus, you don't need to select a primary dentist or obtain referrals to see a specialist.
- **Broad network access:** Access to a seamless national network of over 88,000 participating PDP dentist locations including over 20,000 specialty locations.
- **Valuable cost savings:** Typically, save 10% to 35% below the average fees of dentists in your area when you visit a participating PDP dentist. These dentists agree to accept scheduled fees as payment-in-full for services rendered.
- **Valuable benefit coverage:** Competitive coverage for preventive services as well as more complex dental procedures.
- **Superior claim service:** Making sure you have a great experience with us is our commitment to you. MetLife processes 85% of dental claims in five business days or less. And, if you have questions about your plan benefits, simply call 1-800-942-0854 or log on to www.metlife.com/mybenefits to access tools and information you may want to review to be a better-informed user of your dental plan.

Join us and see what everyone is smiling about!

L060738LL(exp0707)MLIC-LD 0607-1597

Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166 www.metlife.com

HOW TO USE YOUR VISION PLAN

You may elect vision coverage for yourself, or for yourself and your family. The employee pays the full premium for vision coverage. Avesis, Inc. administers the vision plan.

Provider Access

You may choose to receive services from a participating network provider or a nonparticipating provider.

Participating Network Provider Benefits

Receiving services from a participating network provider entitles you to one of the following three benefit options for the plan year:

Option 1 - Standard Lenses

You pay an annual $10 copayment for a routine eye exam and receive standard spectacle lenses and a frame, within the plan allowance, at no additional charge OR

Option 2 - Contacts

If contacts are elective, you pay an annual $10 copayment for a routine eye exam and receive a $130 allowance toward the cost of the contact lenses and fitting fees. If Avesis determines contacts are medically necessary, you pay an annual $10 copayment for a routine eye exam and receive your contact lens benefit at no additional cost OR

Option 3 - Lasik Surgery

You use a participating network provider and receive a $150 benefit allowance toward the cost of Lasik surgery.

Participating Provider Fee Schedule

Participating Provider	Copay	Benefit/Allowance After Copay
1) Vision examination and one of the following:	$10	
a) Single, bifocal, trifocal, or lenticular lenses and frames		$100-$150 retail value
Progressive lenses and frames		20% off retail minus $50 allowance for lenses and $100-$150 retail value of frame
b) Contact Lens: Elective		$130 toward fitting fee and/or contacts
Contact Lens: Medically Necessary*		Covered 100%
c) Lasik Surgery		$150 toward one or both eyes
2) Additional Options		20% discount from provider's fee (i.e., tints, coatings)
3) Additional eyewear		Avesis contracted discounted fee

** Contact lenses would be considered medically necessary for the following conditions: 2) post cataract surgery; b) keratoconus; c) certain conditions of anisometropia; d) extreme visual conditions that cannot be corrected with spectacle lenses. Determination of medical necessity is made by Avesis.*

Purchase of Noncovered Options

If you purchase noncovered options (e.g., eyewear) from a participating network provider, the providers have contracted with Avesis to provide these options at a reduced rate to Avesis members.

Nonparticipating Provider Reimbursement Schedule

When visiting a nonparticipating provider, you will be reimbursed for eligible expenses according to the reimbursement schedule. You will pay the provider and submit an itemized statement for reimbursement of your eligible vision care expenses. Avesis will reimburse you up to the amount shown in the plan's reimbursement schedule. When filing a claim for reimbursement, members should include the following information: your member identification number, your name, the patient's name and date of birth, your mailing address, the group name (State of Arizona) and an itemized statement of expenses. To receive additional information about the vision coverage, please contact Avesis directly at the phone number listed on the contact listing inside this Guide.

Non-Participating Provider Fee Schedule

Non-Participating Provider	Allowance Up To:
Vision Examination	$50
Single Vision Lenses	$30
Bifocal Lenses	$45
Trifocal Lens	$55
Lenticular Lenses	$110
Progressive Lenses	$45
Frames	$50
Contact Lens	
Elective	$150
Medically Necessary	$300
Lasik Surgery	Not Covered

Over 30,000 Arizona State Employees trust Avesis as their vision care provider.

*With the Avesis Vision Plan, employees can save up to $150 per year on exam, frames, spectacle lenses or contacts. Families can save over $500! **

Are you one of them?

Avesis continues to be the State of Arizona's vision care provider for a sixth straight year.

Join your colleagues.

Sign up for the Avesis voluntary vision plan during this open enrollment season.

VISION BENEFITS

Avēsis
A National Vision and Dental Company

3724 North 3rd Street
Suite 300
Phoenix, AZ 85072

FOR MORE INFORMATION ABOUT YOUR STATE OF ARIZONA VISION BENEFITS PLEASE CONTACT CUSTOMER SERVICE AT 1-800-828-9341 OR VISIT WWW.AVESIS.COM/ARIZONA

*Actual savings may be more or less depending on frame selection, lens options and special purchases.

NATIONAL AND INTERNATIONAL COVERAGE (MEDICAL, DENTAL, AND VISION)

Member Coverage Outside of Arizona

	Travel Within the United States	International Travel
MEDICAL CARE		
EPO Plans		
RAN+AMN	Covered with Beech Street Provider	Emergency and Urgent Only
Schaller Anderson	Covered with Beech Street Provider	Emergency and Urgent Only
UnitedHealthcare	Covered with UnitedHealthcare Provider	Emergency and Urgent Only
PPO Plans		
Arizona Foundation	Covered as out-of-network	Covered as out-of-network
Beech Street	Covered as in-network if services provided through a network provider; Out-of-network if services provided through a non-network provider	Covered as out-of-network
UnitedHealthcare	Covered as in-network if services provided through a network provider; Out-of-network if services provided through a non-network provider	Covered as out-of-network
NAU Only		
BlueCross BlueShield PPO	Outside AZ: Covered as in-network only if you receive covered services from a provider who participates as a PPO provider with the local BCBS plan. For assistance in locating a local BCBS network provider in another state, call 1.800.810.2583.	For assistance with locating a provider and submitting claims, call 1.800.810.2583 or 1.804.673.1686. For an international claim form, go to www.bcbs.com/healthtravel/worldwide_claim_form.pdf
PHARMACY BENEFITS		
Walgreens Health Initiatives	Benefits are covered in-network. You may call 1.866.722.2141 to locate a pharmacy in the area in which you are traveling.	Prescriptions cannot be mailed outside of the U.S. You may receive a one-year supply for certain prescriptions through mail-order service prior to leaving the U.S. Please call 1.800.345.1985 to make arrangements. If you obtain medications outside of the U.S., you will not be reimbursed.
DENTAL CARE		
Prepaid Plans		
Assurant	Emergency Only	Emergency Only
Employers Dental Services	Emergency Only	Emergency Only
PPO Plans		
Delta Dental	Benefits are covered as in-network through participating providers and non-network under non-participating provider benefits.	Coverage is available under non-participating provider benefits.
MetLife Dental	Benefits are covered as in-network through participating providers and non-network under non-participating provider benefits.	Coverage is available under non-participating provider benefits.
VISION CARE		
Avesis	Covered using in-network providers. You may call 1.800.828.9341 to locate a vision provider in the area in which you are traveling.	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule

Note: Treatment will be subject to the Plan Description

NATIONAL AND INTERNATIONAL TRAVEL ASSISTANCE

MEDEX Travel Assist provides pre-trip assistance, medical assistance, personal security services, and emergency medical/transportation services throughout the United States ad abroad.

Who Is Covered

All state employees, their spouses, and unmarried dependents under age 19 (through age 24 if a registered student in full-time attendance at an accredited educational institution) are able to use this service.

Pre-Trip Assistance

You can contact the MEDEX Travel Assistance Center at 1.800.633.8575 to receive important information before you leave or while you are en route:

- Consulate and embassy locations
- Currency exchange information
- Health hazards advice and inoculation requirements
- Passport and visa information
- Weather information
- Hotel and airport locator service.

Medical Assistance

If you are outside of Arizona (you must travel more than 100 miles from your residence) or abroad for a maximum of 90 days, MEDEX will assist you with:

- Locating medical care
- Assist in communications with medical providers
- Provide translation and interpreter services 24/7 if you are outside of the United States
- Hotel convalescence arrangements
- Weather information
- Medical insurance coordination for medical care
- Prescription drug assistance to obtain emergency or needed medications.

Emergency Transportation Services

Transportation services are arranged and covered up to a combined single limit of $150,000. Related medical services, medical supplies, and a medical escort are covered where applicable and necessary:

- Repatriation if it is medically necessary after initial treatment and stabilization
- Family or friend travel arrangements if you are hospitalized for more than 7 days and are traveling alone. MEDEX will provide round-trip economy airfare for one family member or friend to the location of your hospital
- Return of dependent children if you are hospitalized for more than 7 days to coordinate the return of a dependent back to the United States. MEDEX will

provide one-way economy airfare for children under age 18 to their permanent residence, including an escort for children, if necessary

- Vehicle return if you require emergency evacuation or repatriation.

Travel Assistance Services
MEDEX provides a variety of travel and technical assistance while you are outside of Arizona or in another country:

- Emergency credit card and ticket replacement for lost, stolen, or damaged cards or tickets
- Emergency passport and document replacement for lost, stolen, or damaged passports or travel documentation
- Emergency cash and payment assistance care
- Emergency message service to relay information to family members
- Missing luggage assistance
- Location of legal assistance
- Bail bond services.

Personal Security Services
MEDEX provides real-time security intelligence in the event you feel you are threatened due to political unrest, social instability, weather conditions, health or environmental hazards. In the event of a threatening situation, MEDEX assists you in making evacuation and logistical arrangements such as ground transportation and housing. MEDEX can also assist in making arrangements with providers of specialized security services.

MEDEX Does Not Cover:

- Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power
- Traveling against the advice of a physician
- Traveling for the purpose of obtaining medical services or treatment
- The commission of, or attempt to commit an unlawful act
- Injury or illness caused by or contributed to by use of drugs or intoxicants, unless prescribed by a physician
- Psychiatric, psychological or emotional disorders, unless hospitalized
- Pregnancy and childbirth, except for complications of pregnancy
- Participation as a professional in athletics
- Expenses incurred for emergency evacuation or repatriation services as a result of injury or sickness while traveling within 100 miles of your place of residence
- Traveling outside your home country for more than 90 days in any one trip.

How to Access Services
You may call 1.800.633.8575 and request a travel assist ID Card. The Group Number for the State of Arizona is 7088.

LIFE INSURANCE BENEFITS

Basic Life Insurance and AD&D

You are automatically covered for $15,000 of basic life insurance at no cost to you. The State also pays for an additional $15,000 of Accidental Death and Dismemberment (AD&D) insurance coverage. A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. You are automatically covered in these three programs. No enrollment is necessary.

Supplemental Life Insurance and AD&D

Supplemental life insurance coverage is available to employees who would like additional life insurance beyond what the State provides. Your cost is based on your age as of October 1st (the first day of the plan year). Your employee supplemental AD&D coverage is the same as the supplemental life amount that you elect. The maximum amount of supplemental life insurance that you can elect through the State's group plan is three times your annual base salary, or $300,000, whichever is less.

When electing supplemental life, you may increase or decrease your supplemental life coverage, in multiples of $5,000, up to a maximum $20,000 increase per year. You may cancel your pretax supplemental life coverage under certain circumstances. Supplemental life coverage above $35,000 is paid on an after-tax basis. You may cancel this aftertax portion at any time during the year.

It is important to keep your beneficiary information current. You may change your beneficiary using the Web enrollment system during Open Enrollment. Remember: adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously-designated beneficiary, you must actively do so while enrolling via the website. If you wish to change your beneficiary outside Open Enrollment, contact your agency benefit liaison.

Dependent Life Insurance

Dependent life insurance coverage is available as a separate election from your Supplemental Life Insurance coverage. You may purchase Spouse and Dependent Life Insurance. Please refer to the eligible dependent section on page 6 of this Guide for a definition of eligible spouse and eligible dependent. Your spouse and eligible children are each insured for the amount you elect: $2,000; $4,000; $6,000; $12,000; or $15,000.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. If you elect coverage for your dependents, you are automatically the beneficiary for your spouse and children.

SHORT-TERM DISABILITY (STD) INSURANCE

If you elect Standard Short-Term Disability (STD) insurance and Standard determines that, based on a medical opinion, you are unable to work due to illness, pregnancy, or a

non-work-related injury, you may receive a weekly benefit for up to six months. The STD benefits will pay up to 66-2/3% of your income during your disability. The weekly minimum benefit is $57.69; the weekly maximum benefit is $769.27. There are no preexisting condition limitations. You must meet the actively-at-work provision. Coverage becomes effective when this provision is met. Your benefits will start on your first day of disability due to accident or the 31st day of disability due to illness or pregnancy, if coverage was elected during your initial new hire/eligibility enrollment period.

If you previously waived STD coverage and enroll during Open Enrollment or due to a Qualified Life Event and become disabled during the first 12 months of coverage, your benefits will start on the 61st day of disability due to illness or pregnancy.

The Standard STD plan provides a Return to Work incentive program. See plan information for details on this program.

LONG-TERM DISABILITY (LTD) INSURANCE

As a benefits-eligible employee, you are automatically enrolled in one of the State's two Long-Term Disability (LTD) programs, starting with your first day of work (participation is mandatory). The retirement system to which you contribute determines the LTD program available to you. Refer to the list below for the name of your LTD program:

Arizona State Retirement System (ASRS): VPA, Inc. is administered through ASRS. Your LTD benefit will pay up to 66-2/3% of your monthly income during your disability as determined by VPA, Inc. and based on supporting medical documentation. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by VPA, Inc. Medical documentation of your disability is required to continue your payment of benefits. You may learn more about the LTD plan offered by ASRS by visiting: www.asrs.state.az.us or calling 602.240.2009 or 800.621.3788 if outside of Phoenix.

Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan (CORP), Elected Officials' Retirement Plan (EORP), Optional Retirement Plans of the Universities (TIAA-CREF, VALC, and Fidelity Investments): Standard Insurance administered through ADOA effective October 1, 2004. Your LTD benefit will pay up to 66-2/3% of your monthly income during your disability as determined by The Standard and based on supporting medical documentation. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by The Standard. Medical documentation of your disability is required to continue your payment of benefits. You may learn more about the LTD plan offered by The Standard by visiting: www.standard.com or calling 800.447.3146.

If you are facing a possible long-term disability, you should contact your agency benefit

liaison or human resources office within 60 to 90 days from the date of your illness or injury for the information you need to apply for LTD benefits. This could include a waiver of insurance premiums (while collecting LTD, the LTD carrier may waive your life insurance premiums) or life insurance conversion (converting your supplemental policy from a group policy to an individual one).

Although your life and/or disability insurance may be waived, your medical, dental and vision insurance premiums are not waived. You are still responsible for payment of these premiums.

STANDARD INSURANCE COMPANY

TheStandard℠
Positively different.

LIFE & DISABILITY INSURANCE

For 12 years, Standard Insurance Company has helped State of Arizona employees safeguard themselves and their loved ones against unexpected loss. Additional Life and Voluntary Short Term Disability insurance from The Standard offers an affordable way to increase your level of protection. At The Standard, we do more than just provide insurance to State of Arizona employees. We help inspire confidence, knowing that someone is there when you need them most.

www.standard.com/mybenefits/arizona 866.440.4846

MEDICAL AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

	MEDICAL CARE	DEPENDENT CARE
Maximum Contributions	$5,000 annually	$5,000 annually ($2,500 if married and filing separately)
Minimum Contributions	$130 annually	$260 annually
Use of the Account	* To pay (with pretax money) for health-related expenses that are not covered or only partially covered by your health plans, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans. * To pay for over-the-counter medications that will be used to treat an existing or imminent condition	* Expenses for care, of an eligible dependent, that is provided inside or outside your home. * Care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home * Dependent care provided so that you can work
Samples of Eligible Expenses	* Copayments * Deductibles * Charges above reasonable and customary limits * Dental fees * Eyeglasses, exam fees, contact lenses and solution, Lasik surgery * Orthodontia * Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers)	* Services provided by a day care facility. Must be licensed if the facility cares for six or more children * Babysitting services while you work * Practical nursing care * Preschool
What's Not Covered	* Premiums for medical or dental plans * Items not eligible for health care tax exemptions by IRS (e.g., cosmetic surgery) * Long-term care expenses	* Private school tuition including kindergarten * Overnight camp expense * Babysitting when you are not working * Transportation and other separately billed charges * Residential nursing home care
Restrictions/Other Information	* See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's web site at www.asiflex.com for specific details on what expenses are allowed * You cannot transfer money from one account to the other * Your election amount may be increased (but not decreased) if you have a Qualified Life Event	* See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's web site at www.asiflex.com for specific details on what expenses are allowed * You may not use the account to pay your spouse, your child who is under age 19 or a person whom you could claim as a dependent for tax purposes * You cannot change your election unless you have a Qualified Life Event

Flexible Spending Life Events/Mid-Year Changes

You cannot change your elections to your Medical or Dependent Care Flexible Spending Accounts after Open Enrollment unless you have a Qualified Life Event as defined by the IRS that causes you, your spouse or a dependent to gain or lose coverage. The requested change must correspond with the gain or loss of coverage and must be submitted in writing within 31 days of the change.

If you have a Qualified Life Event:

- You may increase the amount in either account or both: Medical Flexible Spending Account and/or Dependent Care Flexible Spending Account.
- Midyear reductions to the Medical Flexible Spending Account are not permitted.
- Midyear reductions to the Dependent Care Flexible Spending Account are permitted.

FLEXIBLE SPENDING ACCOUNTS

A flexible benefit plan (also called a Cafeteria Plan or a Section 125 plan) lets you reduce your cost of certain expenses by giving you a tax break on money used to pay for them. These can include medical expenses, not including pre-taxed premiums, dental expenses, vision expenses and over the counter medications. In addition, dependent care accounts offer employees the ability to pay for child care/elder care on a pre-tax basis.

You have the option to participate in the medical and/or dependent care (child care) flexible spending accounts (FSA) administrated by ASI. Here is how they work:

- You must enroll every year – your elections do not carry over to the new plan year.
- You specify the annual dollar amount of your earnings to be deposited in to each account. This annual amount is deducted in 26 equal payments, one each pay period. If you are electing this benefit after the beginning of the plan year, the annual amount will be deducted in equal amounts divided by the remaining pay periods of the plan year. (For example if you elect the benefit on January 15, there are 18 pay periods remaining, the annual election you made is $500.00 for medical; that election is divided by 18 for a pay period deduction amount of $27.77.)
- The amount is deducted from your check before taxes are taken out, lowering your taxable income and possibly lowering your tax liability.
- Throughout the year, after you incur an eligible expense, you submit a claim form and copies of your invoices to ASI for reimbursement. The table on page 42 lists a sample of eligible expenses. To ensure that you will be reimbursed for a given expense, you are encouraged to verify the eligibility of the expense on the ASI website, www.asiflex.com, before incurring the expense.
- ASI reimburses you from the money you have set aside in your Flexible Spending Accounts. ASI processes claims for reimbursement on a daily basis.
- ASI offers direct deposit for your reimbursement and email notification of your reimbursement. Complete the application for direct deposit on the ASI website, www.asiflex.com.

Remember: dependent care is for child care and elder care. Dependent medical and/or other expenses should be submitted through enrollment in the medical spending account - not the dependent care account.

It is important to set aside only as much money in your Flexible Spending Accounts as you intend to use each plan year. Beginning in October 2006, the eligible time to utilize services for claims reimbursement for medical only has been extended for 2 and ½ months. This means you have from October 1, 2006 through December 15, 2007 to utilize services for the plan year beginning on October 1, 2006. All claims for medical expenditures must be filed with ASI prior to the last day of January following the close of the reimbursement period, January 31, 2008, for the plan year beginning October 1, 2006.

Dependent care services must be utilized in the applicable plan year. (For example, child

care services must be incurred between October 1, 2006 and September 30, 2007 for the plan year starting October 1, 2006). Claims for dependent care must be filed at ASI no later than midnight on the last day of December following the close of the plan year. (December 31, 2007 for the plan year beginning October 1, 2006).

Any monies not claimed by the employee within the specified time period allowed will be forfeited in accordance with the Internal Revenue Service Regulations.

Upon Employment Termination

Once your employment is terminated:

- You may continue to submit claims for expenses incurred through your termination date but not incurred after your termination date.
- You forfeit any remaining monies unless you elect to continue FSA contributions through COBRA until the end of the plan year.

If you elect to continue FSA through COBRA, your contributions will be post-tax and the amount will be calculated as follows:
An additional 2% per pay period for the remaining number of pay periods will be charged in addition to the original pay period amount for administration of FSA under COBRA.

In order to assist you in calculating expenses for medical and/or dependent care, a form has been provided to aid you at www.benefitoptions.az.gov under the flexible spending account link for employees.

FLEXIBLE SPENDING ACCOUNTS (FSA) WORKSHEET

Deciding How Much to Deposit

Calculate the amount you expect to pay during the plan year and calendar years for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed the established IRS calendar year or your employer's plan year limits (Medical limit = $5,000; Dependent Care limit = $5,000). Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you.

TAX-FREE MEDICAL EXPENSE WORKSHEET	TAX-FREE DEPENDENT CARE WORKSHEET
Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is October 1, 2006 through December 15, 2007	Estimate your eligible dependent expenses for the plan year, which is October 1, 2006 through September 30, 2007
YOUR UNINSURED MEDICAL, DENTAL, AND VISION EXPENSES $_____ $_____ $_____ $_____ $_____ $_____	NUMBER OF WEEKS you will have dependent (child, adult or elder) care expenses from October 1 through September 30, for the plan year. Remember to subtract holidays, vacations, and other times you may not be paying for eligible child adult, or elder care. Weeks _____
SUBTOTAL Estimated eligible uninsured medical expenses for your period of coverage during the year cannot exceed $5,000 $_____	MULTIPLY by the amount of money you expect to spend each week $_____ SUBTOTAL Remember, your total contribution cannot exceed IRS limits for the calendar year and your employer's plan year*. $_____
DIVIDE by the number of paychecks you will receive during the plan year*. This is your pay period contribution*= $_____	DIVIDE by the number of paychecks you will receive during the plan year*. This is your pay period contribution*= $_____
* If you are a new employee enrolling after the plan year has started, divide the number of pay periods remaining in the plan year.	* If you are a new employee enrolling after the plan year has started, divide the number of pay periods remaining in the plan year.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. To obtain an application, visit the ASI website at www.asiflex.com.

Tax Credit

There are additional IRS rules that apply to your Dependent Care Flexible Spending Account

contributions. You may be eligible to claim the dependent care tax credit on your Federal income tax return. You may want to consult a tax advisor to determine whether participating in the Dependent Care Flexible Spending Account or taking the dependent care tax credit gives you the greater advantage.

Using Your Flexible Spending Accounts

You have several options for obtaining and filing a claim against your Flexible Spending Account. You may obtain a claim form in the following ways:

- On the web - You may download a claim form at www.asiflex.com.
- On the phone - You may call ASI at 1.800.659.3035 and request a claim form.
- By mail - You may request a claim form by sending a written request to: P.O. Box 6044, Columbia, MO 65205.

You will need to fill out your claim form and attach copies of invoices for services you received. Mail the claim form to the address shown above and wait to receive your reimbursement by direct deposit or check. If you wish to start direct deposit of your reimbursements after the Open Enrollment period, you will need to do so through ASI. The direct deposit request form is available at www.asiflex.com. You may also have your statements sent to you by email. Go to www.asiflex.com and follow the links to sign up. See your agency benefit liaison if you have questions or problems obtaining or submitting a claim.

Beginning in October 2006, the eligible time to utilize services for claims reimbursement for medical only has been extended for 2 and ½ months. This means you have from October 1, 2006 through December 15, 2007 to utilize services for the plan year beginning on October 1. 2006. All claims for medical expenditures must be filed with ASI prior to the last day of January following the close of the reimbursement period (January 31, 2008, for the plan year starting October 1, 2006).

COBRA CONTINUATION OF COVERAGE NOTICE

Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the State of Arizona group health insurance plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by the State of Arizona (the "State") under the Plan (i.e., medical, dental, vision and health care Flexible Spending Account {FSA}) and not to any other benefits offered by the State (such as life insurance, disability, or accidental death and dismemberment). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

How can you elect COBRA coverage?
To elect COBRA coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver by the date specified on the Election Form to the ADOA Benefits Office as indicated on the Election Form. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA under the Health Care FSA
COBRA coverage under the health care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health care FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for health care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the health care FSA, if elected, will consist of the health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year, and COBRA coverage will terminate at the end of the Plan year. All qualified beneficiaries who were covered under the health care FSA will be covered together for health care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits Office (see "For More Information" section below).

Special Considerations in deciding whether to elect COBRA
In considering whether to elect COBRA coverage, you should take into account that a failure

to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA coverage may eliminate this gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How long will COBRA coverage last?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the Plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid-in-full on time,
- a qualified beneficiary becomes covered, after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage, or
- the State ceases to provide any group health plan for its employees; or

- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage as in a case of fraud). You must notify the applicable carrier(s) (see "For More Information" section on page 50) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrators, insurance carriers and/or HMOs may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How can you extend the length of COBRA coverage?
If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. (The period of COBRA care FSA cannot be extended beyond the end of the current Plan year under any circumstances).

Disability
If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the applicable carrier(s) (see "For More Information" section on page 50) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date of which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" section).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier(s) of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the applicable carrier(s) (see "For More Information" section) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event;
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Benefits Once requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or leer from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to the ADOA Benefits Office at the addresses indicated below (see "For More Information" section).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

How much does COBRA coverage cost?
Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

When (and how) must payment for COBRA coverage be made?
First payment for COBRA coverage. If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the ADOA Benefits Office to confirm the correct amount of your first payment.

Monthly payments for COBRA coverage
After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for

each coverage period for each month for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage) – it is your responsibility to pay your COBRA premiums on time.

Grace periods for monthly payments
Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Your first payment for COBRA coverage should be sent to the following:

Note: Although initial payment is mailed to ADOA, payments must be made payable to the applicable for which you are electing coverage.

ADOA Benefits Office
100 N. 15th Avenue, Ste. 103
Phoenix, AZ 85007

Checks should be made payable to:

- UnitedHealthcare for any of the UHC plans
- Fiserv Health - Harrington Benefit Services for any of the following plans: Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson
- Dental premiums should be made payable to the dental carriers: Delta, MetLife, EDS or Assurant
- Vision premiums should be made payable to Avesis
- Flexible Spending premiums should be made payable to ADOA/HITF

After the initial payment, your monthly payments will be sent to the individual administrator/carrier. You will receive an invoice each month that will include the applicable address. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments

made after the grace period will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries Children born to or placed for adoption with the covered employee during COBRA coverage period
A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Alternative recipients under QMCSOs
A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the State during the covered employee's period of employment with the State is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered employee.

For more information
This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Benefits Office.

If you have any questions concerning the information in this notice or your rights to COBRA coverage, you should contact the following:

ADOA Benefits Office
100 N 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687

Information about COBRA provisions for governmental employees is available from the:

Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16 Baltimore, Maryland 21244-1850

Or you may call 1.410.786.1565 for assistance. This is not a toll-free number. The CMS website is www.cms.hhs.gov.

Keep your plan informed of address changes
In order to protect you and your family's rights, it is important that you keep the ADOA Benefits Office and the applicable health plan administrator(s) informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the ADOA Benefits Office and or the applicable health plan administrator(s).

ADDITIONAL BENEFITS

The State of Arizona offers many benefits to its employees. Here is information on other benefits for State Employees.

Note: Arizona Department of Public Safety employees shall refer to the Law Enforcement Merit System Council (LEMSC) rules for leave policies and rules.

Employee Assistance Program (EAP)
The Employee Assistance Program (EAP) is one of your many benefits as an employee of the State of Arizona. Please use this benefit as needed. EAP is available to assist you in achieving and maintaining your highest level of job performance. EAP provides you with the opportunity to resolve a wide range of personal and job-related issues. If you need assistance in addition to your usual coping skills to deal with personal or job related issues, EAP may be the answer. Visit the EAP website at www.benefitoptions.az.gov/EAP.

Arizona Government University (AZGU)
The Arizona Government University is a model for State Government in the training and development of its most critical core competency, the estimated 42,000 State employees and related public personnel that serve the Arizona constituency. Arizona Government University was created at the request of State agencies to create a more efficient, effective, affordable and customer-focused learning for the State of Arizona. A Board, representing State agencies, has oversight for the direction of AZGU. AZGU's mission is to create a workforce development program that delivers critical competencies and skill sets to enable employees to develop professionally and to deliver cost-effective, customer-focused, State government services.

Children's Day Care Center
State employees who have children or grandchildren are eligible to enroll those dependents in the Child Care Development Center. The center is operated by LaPetite Academy and is accredited and licensed.

The facility is located at 1937 W. Jefferson Street, Phoenix, Arizona. The cost for enrollment varies by the age of the child. For more information or for a tour of the facility, contact the Child Care Development Center's Director at 602.542.1937.

457 Deferred Compensation Plan
Nationwide Retirement Solutions, formerly PEBSCO, provides public employees their 457 deferred compensation plan. The Plan allows state employees to invest pre-tax dollars into a supplemental retirement account. The state oversees the administration of the Plan while NRS provides enrollment, plan administration and retirement education.

Maximum Deferral:$14,000.00, or 100% of Includible Compensation, for 2006 unless eligible for catch-up provisions, in which case you might be able to defer more.

Minimum Deferral:$10.00 per pay period, $20.00 per month

The amount you choose to contribute to your program will depend on your specific situation. There is no "one-size-fits-all" solution. Your strategy will likely involve contributing as much as you can on a regular basis. The strategy you choose will depend on many variables, including the amounts you might receive from your pension and Social Security, what your investments earn between now and the time you retire, and what kind of standard of living you want at retirement. Regardless of how much you can afford to contribute, there are benefits to joining the deferred compensation program sooner rather than later.

So, if you are ready to start building for retirement and postponing federal and state taxes at the same time, today is the day to start turning a portion of your paycheck into an investment for your future.

Please contact a local representative at 602.266.2733 (or toll free at 1.800.796.9753) to schedule a consultation or for a list of scheduled educational seminars. You may also visit the local office at 4747 N. 7th Street, Suite 418, Phoenix, Arizona (office hours: 8 a.m. to 5 p.m.).

Arizona State Savings and Credit Union
Arizona State Savings & Credit Union has been serving the financial needs of Arizona families since 1951. Today, your credit union proudly serves employees of the State of Arizona, American Express, and faculty, staff, students and alumni of Arizona State University, University of Arizona, and Northern Arizona University. Membership is also open to residents of Coconino County, Yavapai, Graham, Greenlee, and portions of northern Gila and southeastern Maricopa County.

Paid Time Off
As part of your compensation as a State employee, you receive paid time off. For detailed information regarding paid time off, review the State of Arizona Personnel Rules, Article 4. A

State Service Holidays
The State has 10 holidays.

- January 1, New Year's Day
- 3rd Monday in January, Martin Luther King, Jr./Civil Rights Day
- 3rd Monday in February, Lincoln/Washington/ Presidents' Day
- Last Monday in May, Memorial Day
- July 4, Independence Day
- 1st Monday in September, Labor Day
- 2nd Monday in October, Columbus Day
- November 11, Veterans' Day
- 4th Thursday in November, Thanksgiving Day
- December 25, Christmas Day

**If the holiday falls on Saturday, then it is observed on Friday. If the holiday falls on Sunday, then it is observed on Monday.

Agency Specific Benefits

Your agency may provide other benefits, such as an agency newsletter, Employee Assistance programs, award programs and/or recognition leave. For information regarding your agency, ask your agency Human Resources/Personnel office.

Credited Service	Hours Accured Biweekly
Less than 3 years	3.7
3 years but less than 7 years	4.62
7 years but less than 15 years	5.54
15 or more years	6.47

Sick Leave

Eligible employees accrue sick leave at the rate of eight hours per month. Eligible part-time employees accrue sick leave proportionate to the number of hours worked according to an established schedule. Accumulation is unlimited.

Employees who retire with 500 or more unused sick leave hours may file for accumulated sick leave benefits through their personnel office.

Miscellaneous Paid Leave

Personnel Rules cover the request for and use of the following leaves:

- Civic Duty Leave
- Military Leave
- Educational Leave
- Bereavement Leave

Be sure to follow the personnel rules and your agency's guidelines if the need should arise for these leave categories.

Parental Leave

Parental Leave is any combination of annual leave, sick leave, compensatory leave, or leave without pay (LWOP) taken by an employee due to pregnancy, childbirth, miscarriage, abortion or adoption of children.

Leave Without Pay (LWOP)

LWOP is defined as a leave which has been approved in advance, in writing, for a period of time, when there will be no paycheck from the employer.

The State's Personnel Rules explain the procedures and conditions for LWOP including authorization, use, documentation, return to work, and benefits.

If in the future you are on LWOP, be sure you and your Benefits Liaison fully discuss your benefit options, costs, and the effect your benefit decisions will have on your benefits upon your return to work. When your LWOP begins, you can make changes to your coverage,

such as switching from family to single coverage, lowering the amount of supplemental life or declining some or all coverage.

Generally, an employee who is on LWOP must pay both the employee and employer portion to maintain medical and dental health care coverage and basic life insurance. Vision, supplemental life insurance and disability coverage have only employee paid premiums. The only exceptions are approved LWOP due to industrial disability, leave covered by the Family and Medical Leave Act (FMLA), or military leave. Employees on Industrial, FMLA or Military leave may continue benefits by paying just the employee portion for periods of time established by applicable laws and rules. After those time limits are reached, if the employee is still on leave, the employee must pay both the employer and employee portions of premiums to continue coverage.

If the employee on LWOP allows premium payment to become delinquent, coverage terminates. If the employee was cancelled for non-payment, the employee cannot re-enroll until the next open enrollment after the employee returns to work. If the employee was not cancelled for non-payment of premium, the employee can restore the coverage changed at the start of the leave, upon his or her return to active employment.

An employee who must go on LWOP has many decisions to make and should fully discuss them with his or her Benefits Liaison. Employees returning from LWOP should check their payroll deductions for any discrepancies with the coverage choices made.

When You Leave State Service

Termination

If you should terminate employment with the State of Arizona, most likely you will have insurance continuation rights, for certain coverage, under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The former employee who elects this continuation of coverage pays 102% of the full monthly premium (employee cost + employer cost + 2% administrative fee).

Retirement

When you retire from State service, you have the option of continuing medical, dental and/or vision coverage through the ADOA Benefit Options Program or electing coverage through the program sponsored by your retirement system. Retirees pay the entire monthly premium; however, if you qualify, your retirement system may subsidize your monthly medical and/or dental premium in an amount related to your length of service. Many retirees who have Medicare A and B can choose a Medicare Contract HMO, and the State subsidy may cover the entire medical and dental plan premium. Retirees may also elect COBRA coverage.

Retires who choose COBRA coverage or retirement system coverage may not later return to the plan sponsored by ADOA. However, those retirees who elect COBRA coverage may elect coverage through their retirement system when their COBRA coverage terminates.

GLOSSARY OF TERMS

Actively at Work
Employees are considered actively at work on an employer's scheduled workday if they are performing in the usual manner all of the regular duties of their work on a full-time basis on that day, whether at their usual place of work or at another place if required to travel. Employees are also considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled workdays only if they were actively at work on the preceding scheduled workdays

Allowed Fees
Term used by some dental plans for their participating dentist fees and/or maximum payable for a non-participating dentist.

Coinsurance
The division of the allowed amount to be paid by the insurance and the patient, i.e., 50/50, 70/30, or 80/20 after the deductible is satisfied (the first percentage is paid by the insurance-70 or 80).

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying life event as defined in the Act.

Coordination of Benefits
A process used to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

Copayment
The fixed fees that must be paid to the provider at the time services are provided, such as the pharmacist for a prescription.

Deductible
The initial amount the patient must pay out of their pocket for covered services before benefits are payable by insurance in indemnity or PPO plans.

Emergency
Defined by each plan in accordance with the standard definition.

Eligible Employee
State employee regularly scheduled to work 20 hours or more per week.

Enrollee
A person (employee, COBRA participant or dependent) who has met the eligibility

requirements and is enrolled in an insurance plan.

EPO (Exclusive Provider Organization)
An EPO follows the same guidelines as an HMO plan. You must obtain services from a contracted network provider.

Full-time Student
An unmarried child who is 19 years of age but less than 25 years of age who is enrolled in and attending a high school, or a post-secondary accredited institution of learning on a full-time basis as defined by the institution.

Incurred Expense
An expense is considered incurred on the date services were rendered or supplies were received.

Identification Number
Number issued by the employer and/or insurance provider for utilization of services.

Plan Year
October 1 through September 30.

PPO (Preferred Provider Organization)
Allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a deductible and will pay a percentage of all covered services.

Premium
The amount a covered person and/or employer pays in exchange for insurance coverage.

Self-Insured Plan
A self-insured plan is one in which the employer or group of employers assumes the direct financial responsibility for the costs of enrollees' health insurance claims. Employers sponsoring self-insured plans typically contract with an insurance carrier or third party administrator to provide administrative services for the self-insured plan.

NOTICE OF THE ARIZONA BENEFIT OPTIONS PROGRAM PRIVACY PRACTICES

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to Arizona Benefit Options refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the soliciation of health plans or the modification or amendment of the existing plan.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In The Event of a Serious Threat to Health or Safety Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Arizona Benefit Options maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you with to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF ARIZONA BENEFIT OPTIONS

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602.542.5008 (outside the Phoenix area, toll free at 1.800.304.3687), or by email at beneissues@azdoa.gov. You may also obtain a copy of this Notice at our web site at www.benefitoptions.az.gov. The ADOA Privacy Officer may be contacted at 100 N. 15th Avenue, Suite 401, Phoenix, Arizona 85007.

EFFECTIVE DATE

This Notice is effective April 14, 2003.